IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

November 15, 2006

Joan Stockton, Administrator
Community Restorium
6619 Kanisku Street
Bonners Ferry, ID 83805

FILE COPY

License #: RC-118

Dear Ms. Stockton:

On August 24, 2006, a complaint investigation, state licensure survey was conducted at Community Restorium. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Patrick Hendrickson, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

PATRICK HENDRICKSON, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 25, 2006

FILE COPY

Virginia Wilkerson
Community Restorium
6619 Kanisku
Bonners Ferry, ID 83805

Dear Ms. Wilkerson:

In your letter to the Bureau of Facility Standards, dated September 20, 2006, you requested additional time to resolve the non-core punch list items and the core issue cited on the statement of deficiencies for the standard health care survey conducted on August 24, 2006. The Bureau has considered your request and is granting a 20 day extension. The new date for your evidence of resolution and plan of correction to be received by this office is October 16, 2006.

If you have any questions please call 334-6626.

Sincerely,

PATRICK HENDRICKSON, R.N.
Health Facility Surveyor
Residential Community Care Program

PH/slc

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL 7003 0500 0003 1967 1251

September 8, 2006

Virginia Wilkerson, Administrator
Community Restorium
6619 Kanisku Steet
Bonners Ferry, ID 83805

FILE COPY

Re: Enforcement Action – Community Restorium

Dear Ms. Wilkerson:

As a result of the standard survey conducted on August 24, 2006, Community Restorium was issued a core issue deficiency for inadequate care. This core issue substantially limits the capacity of Community Restorium to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

Due to the seriousness of this core issue and in accordance with IDAPA 16.03.22.900.04. the following enforcement actions are imposed:

1. **The facility will correct the deficient area in accordance with the submitted Plan of Correction no later than October 8, *2006*;**
2. **A registered nurse consultant, with a background in residential care and/or long term care, will be obtained and paid for by the facility, and approved by the Department. This registered nurse consultant may not also be employed by the facility as a regular employee. The registered nurse consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than September 15, *2006*;**
3. **The Department approved consultant will submit a weekly written report to the Department commencing on September 22, *2006* and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statements of Deficiencies and Non-Core Issues Punch Lists.**

4. **The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction;**

5. **A provisional license is issued which is to be prominently displayed in the facility. Upon receipt of this provisional license return the full license, currently held by the facility.**

6. **When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Randy May
Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

Staff from the Residential Community Care Program is available to help avoid additional negative actions. Should you desire technical assistance, please contact this office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

Enclosure

c: Sharon Duncan, Chief, Bureau of Long Term Care and State Operations
Tanya McElfresh, Regional Manager Long Term Care Services Region I and II
Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Randy May, Deputy Administrator, Division of Medicaid
Willard Abbott, Deputy Attorney General, Human Service Division
Patrick Hendrickson, R.N., Health Facility Surveyor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

September 8, 2006

CERTIFIED MAIL #: 7003 0500 003 1967 1251

Virginia Wilkinson, Administrator
Community Restorium
6619 Kanisku Street
Bonners Ferry, ID 83805

FILE COPY

Dear Ms. Wilkinson:

Based on the complaint investigation, state licensure survey conducted by our staff at Community Restorium on **August 24, 2006,** we have determined that the facility failed to protect resdients from inadequate care. The facility failed to assure that residents rights were observed and protected by providing a safe living environment for 1 of 1 sampled residents identified as at risk for wandering outside and off of the facility property (resident #2).

This core issue deficiency substantially limits the capacity of Community Restorium to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **October 8, 2006. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **September 21, 2006,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 21, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 21, 2006,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **September 23, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Community Restorium.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Loren Quinton, R.N., Program Manager, Regional Medicaid Services, Region I - DHW

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments	R 000		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: I. Residents Rights -Safe Environment Based on observations, interview and record review it was determined the facility failed to assure that residents rights were observed and protected by providing a safe living environment for 1 of 1 sampled resident identified at risk for wandering outside and off of the facility property (#2). The findings include: Review of Resident #2's record on 8/23/06 revealed the resident was admitted on 6/30/06, with a diagnosis of dementia. The resident's record contained a "New Resident Overview" dated 6/30/06, that stated the resident's "main issues surround her confusion and short term memory, and the family would appreciate "vigilance" about her walking or being outside alone." The resident's record contained the following "Daily Log" notes dated from 7/4/06 to 7/16/06: On 8/23/06 at 10:30 a.m., 3 staff members stated Resident #2 wanders into other resident rooms and "shops." Additionally, they stated other	R 008	**1. Residents Rights—Safe Environment** **1. Corrective action for specific resident areas** **A. Resident # 2** **1. Easily re-directed by staff** **2. Adjusting to this new location** **3. Family re-decorated resident room to help reinforce familiarity/comfort** **4. Has joined an ambulatory "womans" group for activity** **5. Exit door alarm system activated 24-7** **6. Staffing includes immediate response to all door alarms and visual checks of source as well as individual resident checks as to where abouts.** **2. Identify other residents that may be affected by same** **A. Review all residents for wandering and supervision needs** **B. Revise plan of care accordingly** RECEIVED SEP 22 2006 FACILITY STANDARDS	

Bureau of Facility Standards

Virginia Wilkinson, Administrator — TITLE — (X6) DATE 9/19/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 1 residents have to go outside with Resident #2, "so she doesn't wander away from the facility." On 8/24/06 at 6:05 p.m., Resident #2 was observed to exit the front entrance of the facility and wander toward the street. At that time two residents and a staff member were observed chasing the resident through the parking lot to prevent the resident from leaving the facility grounds. On 8/24/06 at 7:30 p.m., the administrator confirmed Resident #2 required constant supervision when she was outside to prevent the resident from wandering off of the facility grounds. The facility failed to maintain a safe and secure environment to prevent Resident #2 from wandering from the facility. This failure resulted in inadequate care. II. Emergency Interventions Based on interview and record review it was determined the facility failed to obtain emergency services for 1 of 7 residents reviewed (#7). The findings include: Review of the facility's "Emergency Policy" on 8/24/06, documented "If staff determines there is no trauma and the resident is able to sit independently in a wheelchair and can be transported safely to emergency room do so" or " if there has been trauma call 911." Review of Resident #7's record on 8/23/06 revealed the resident was admitted on 10/6/03 with diagnoses which included hypertension and chronic obstructive pulmonary disease.	R 008	3. Measures or changes to make sure does not recur A. Implementation of an exterior door locking system tied to the emergency response and alarm panel. A coded key pad installed at main entry B. Installation by Fire Systems West 4. How corrective actions will be monitored and how often to prevent reoccurence A. Random door checks by administrator, county commissioners, staff and designated individuals 5. Date corrective action will be completed October 8, 2006 **II Emergency Interventions** 1. Corrective action for specific residents A. Resident # 7 1. Reassess for risk for falls and amend plan of care to meet determined care needs 2. In-service staff regarding individual safety needs for fall prevention	

Virginia Wilkerson Administrator 9/19/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 2 Review of the facility's "Incident Report" log on 8/24/06 revealed that on 06/28/06 at 8:30 p.m. the resident was "found on the floor" and "has a bit of a headache." It further stated the facility did not notify the resident's doctor, facility's nurse or the resident's family were notified of the fall nor was first aid applied. Review of the facility's Journal on 8/24/06 revealed that on 6/29/06 around 6:40 a.m. the resident was taken to the hospital due to dizziness and inability to walk. Further it stated the resident was admitted to the hospital due to a hematoma between his brain and skull. Review of the hospitals "Emergency Department Charting Form" stated the resident arrived to the emergency room on 6/29/06 at 6:47 a.m. for complaints of dizziness, incontinence and a headache. Review of the hospitals "Emergency Physician Record" stated the resident fell from a standing position striking the back of his head. Further it stated the resident complained of a headache, difficulty walking, difficulty with speech and confusion. Review of the hospitals cat scan results documented the resident had a large right sided subdural hematoma and a midline shift to the left at 9 mm. On 8/24/06 at 3:30 p.m., a staff member confirmed that on 6/28/06 the resident was found on the floor by staff and the resident had a large "goose egg" on his head and complained of a headache after hitting his head during a fall. Further, she stated on 6/29/06 when she arrived	R 008	2. Identify other residents that may be affected by: A. Reassessment of each resident B. Develop list of at-risk residents for falls and wandering C. In-service all staff on care needs for high-risk individuals 3. Measures or changes to make sure does not recur A. Review emergency policy and procedures 1. Update as needed 2. In-service all staff on emergency policy and procedures 4. How corrective actions will be monitored and how often to prevent re-occurence A. Administrator notified of all reportable incidents within 24 hours B. Emergency and reporting policies posted in office C. In-service all staff on emergency and reporting policies D. Administrator review of incidents and incident log every three days E. Follow up as needed 5. Date corrective action will be completed October 8,2006	

Virginia Wilkinson, Administrator 9/19/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 3 to work at 6:00 a.m. she was asked by the administrator to drive the resident to the hospital in her personal vehicle due to the residents complaints of dizziness and inability to walk. She confirmed the resident was admitted to the hospital due to a hematoma between his brain and skull. On 8/23/06 at 3:50 p.m., the administrator confirmed that on 6/28/06, the resident was found on the floor by staff and the resident had complained of a headache after hitting his head during the fall. Further, she stated the resident was not taken to the hospital until 6/29/06 6:47 a.m. The facility failed to obtain emergency services for resident #3 when he had a fall from a standing position striking his head and un-unlicensed staff did not notify the facilities nurse or 911 to assess the resident for injury. Further the facility transported the resident in a employees personal vehicle when the facility's police states " if there has been trauma call 911." This failure resulted in inadequate care. III. Acceptable Admissions Based on interview and record review it was determined the facility retained residents who were violent, had emotional needs and were not compatible with other residents. This was true for 2 of 7 sampled residents (#3 and #5). The findings include: 1. Review of Resident #3's record on 8/23/06 revealed the resident was admitted on 10/6/03 with a diagnosis of dementia. Review of the facility's "Incident Report" log on	R 008	**III. Acceptable Admissions** 1. Corrective actions for specific residents A. Resident # 3 1. Relocation to another facility 9/5/2006 B. Resident # 5 1. Relocation to another facility 9/4/2006 2. Identify other resident that may be affected by: A. Review all residents for behaviors not appropriate to facility and who do not meet admission policy requirement B. Relocate residents who do not meet admission requirement C. Develop Care Plan Review Committee to meet every two weeks to review each resident, behaviors and care needs 1. Suggest other appropriate housing if necessary for any resident not meeting acceptable admission standards due to behaviors or other care needs.	

Virginia Wilkinson Administrator 9/19/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 4 8/24/06 revealed the resident "Got very upset" "yelled and cussed" and "reached across the bed and got a handful of hair." Review of the facility's "Journal" on 8/24/06 revealed that on 8/15/06 at 3:40 p.m. the resident "got very upset and shook her cane at me" and said " she was going to hit me with her cane." On 8/23/06 at 10:50 a.m. a staff member stated the resident could be physically aggressive with staff and also was incontinent of stool that she smears over walls. On 8/23/06 at 11:00 a.m. a second staff member stated the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. On 8/23/06 at 11:15 a.m. a third staff member stated the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. On 8/23/06 at 11:20 a.m. the administrator confirmed the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. On 8/24/06 at 1:20 p.m. a random cognitive resident confirmed the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. Review of the facility's Admission Policy on 8/24/06 documented the facility shall not retain residents who are violent. 2. Review of Resident #5's record on 8/23/06	R 008	3. Measures or changes to make sure does not recur: A. Review admission and discharge policies for updates as necessary B. In-service all staff on updates and general policy C. Compare all new possible admissions to updated admission policy D. Admit only residents who meet admission policy requirements 4. How corrective actions will be monitored and how often to prevent re-occurance A. Review of each new resident for non-compatible behaviors every two weeks by care plan review committee after admission B. Follow up as necessary 5. Date corrective action will be completed: October 8, 2006	

Virginia Wilkinson Administrator 9/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 5 revealed the resident was admitted on 12/29/03 with a diagnosis of dementia. On 8/23/06 at 10:30 a.m., three staff members stated Resident #5 "goes into Resident #4's room." Additionally, they stated Resident #5 stands in the doorways of the female residents' rooms and "rubs his penis" and "attempts to masturbate in front of them." On 8/23/06 at 2:30 p.m., the administrator stated Resident #5's inappropriate behavior had started in May 2006. She stated several female residents had approached her regarding concerns about Resident #5's behavior. She stated that staff have also complained to her that during the entire bathing process, Resident #5 has an erection and attempted to touch them. Review of the facility's Admission Policy on 8/24/06 documented the facility shall not retain residents who's social needs are not homogeneous with the other residents in the facility. The facility retained residents who were violent and had emotional needs that were not compatible with other residents and against the facility's policy for 2 of 7 sampled residents (#3 and #5) these failures resulted in inadequate care. Further, the facility's failure to provide a safe environment, provide emergency interventions, and the retention of residents who's social needs are not homogeneous with the other residents in the facility constituted immediate danger and had the potential to adversely affect 100% of the residents in the facility. The facility was informed of the immediate danger situation on August 24,	R 008		

Virginia Wilkinson Administrator 9/19/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 6 2006, and an acceptable plan of correction was obtained at that time. IV. NSA - Behavior Management: Based on interview and record review it was determined the facility failed to develop BMPs to identify and describe residents behavior management needs for 4 of 7 sampled residents (#'2, #3, #4 and #5). The findings include: 1. Review of Resident #2's record on 8/23/06, revealed the resident was admitted on 6/30/06 with a diagnosis of dementia. Further review of the resident's record revealed no documented evidence of a BMP. The resident's record contained a New Resident Overview sheet that documented the resident's "main issues surround her confusion and short term memory, and the family would appreciate "vigilance" about her walking or being outside alone." The resident's record contained the following "Daily Log" notes dated from 7/4/06 to 7/16/06: On 7/4/06 (un-timed) Resident #2 tried to drop her pants in the hallway. On 7/8/06 (un-timed) staff had to remove Resident #2 from another resident's room. On 7/16/06 (un-timed) Resident #2 wandered into another resident's room and took the resident's glasses.	R 008	**IV NSA-Behavior Management** 1. Corrective action for specific residents: A. Resident # 2 Behavior Management plan developed and in place B. Resident # 3 Interim Behavior management plan developed and faxed to Bureau of Facility Standards. Resident discharged to another facility C. Resident # 4 Interim Behavior management plan developed and faxed to Bureau of Facility Standards.. Resident discharged to another facility D. Resident # 5 Interim Behavior management plan developed. Resident discharged to another facility. 2. Identify other residents who may be affected by: A. Evaluate all current residents for need for a behavior management plan B. Develop and use a behavior management worksheet to track behaviors and implement an appropriate behavior plan C. Implement an appropriate behavior management plan to address behaviors D. In-service all staff on behavior management tracking worksheet and development of an appropriate behavior management plan	

Virginia Wilkerson Administrator 9/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 7 On 8/23/06 at 10:30 a.m., 3 staff members stated Resident #2 wanders into other resident rooms and "shops." Additionally, they stated other residents have to go outside with Resident #2, "so she doesn't wander away from the facility." On 8/24/06 at 6:05 p.m., Resident #2 was observed to exit the front entrance of the facility and wander toward the street. At that time two residents and a staff member were observed chasing the resident through the parking lot to prevent the resident from leaving the facility grounds. On 8/24/06 at 7:30 p.m. the administrator confirmed Resident #2 wandered into other resident rooms at times, and required constant supervision when she was outside to prevent the resident from wandering off of the facility grounds. 2. Review of Resident #3's record on 8/23/06 revealed the resident was admitted on 10/6/03 with a diagnosis of Dementia. Further review of the resident's record revealed no documented evidence of a BMP. Review of the facility's Incident Report log on 8/24/06 documented the resident "Got very upset" "yelled and cussed" and "reached across the bed and got a handful of hair." Review of the facility's Journal on 8/24/06 documented that on 8/15/06 at 3:40 p.m. the resident was dressed in night clothing and when staff tried to point this out to the resident "She got very upset and shook her cane at me" and said " she was going to hit me with her cane."	R 008	3. Measures or changes to make sure does not recur A. Care plan review committee review each resident with a behavior tracking worksheet and/or behavior management plan B. Administrator generate NSA/care plan addendum to address related care needs based on information from worksheet C. Behavior tracking worksheet used by and submitted by care staff for further development 4. How corrective actions will be monitored and how often to prevent re-occurence A. Care plan review committee meet every two weeks for review, needed corrective steps and follow-ups as necessary 5. Date corrective action will be completed October 8, 2006	

Virginia Wilkinson Administrator 9/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 8 On 8/23/06 at 10:50 a.m. a staff member stated the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. On 8/23/06 at 11:00 a.m. a second staff member stated the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. On 8/23/06 at 11:15 a.m. a third staff member stated the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. On 8/23/06 at 11:20 a.m. the administrator confirmed the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. She further confirmed there was not a BMP developed for the resident. On 8/24/06 at 1:20 p.m. a random cognitive resident confirmed the resident could be physically aggressive with staff and was incontinent of stool that she smeared on the walls. 3. Review of Resident #4's record on 8/23/06 revealed the resident was admitted on 10/13/05 with a diagnosis of dementia. Further review of the resident's record revealed no documented evidence of a BMP. The resident's record contained the following "Daily Log" note dated 7/26/06: Two other residents witnessed Resident #4	R 008		

Virginia Wilkinson Administrator 9/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 9 pushing a male resident because the male resident was in Resident #4's way. On 8/23/06 at 10:30 a.m., three staff members stated Resident #4 frequently wandered into other resident rooms. Additionally, they stated the resident was physically abusive to other residents. Review of the "Resident Concerns/Issues Report" revealed the following complaints: On 8/4/06 (un-timed), "Intrusion of privacy, party frequently comes into my room without knocking... listens to conversations when I have guests and sometimes enters and starts joining in. But today she came into the bath and started talking to the bath aide while I was in the tub... Somehow there must be some way to stop her, I like my privacy." On 8/8/06 (un-timed), a male resident went to the administrator and complained that he was getting tired of Resident #4 trying to get him to do things for her. The resident asked him to walk her to the corner so she could "hitch" a ride to church. When the male resident refused Resident #4 asked him to take her to buy a car. Additionally, the male resident stated Resident #4 was getting more "outrageous" with her ideas. "The other day she asked me if I was willing to dress her." The resident stated he felt Resident #4's recent behavior and approach, "was over the line." On 8/11/06 at 7:10 a.m., Resident #4 had a "loss of temper, upset all the time, confused, entering rooms without permission, wanting help getting undressed." On 8/23/06 at 2:30 p.m., the administrator	R 008		

Virginia Wilkins Administrator 9/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 10 confirmed Resident #4 wandered into other resident rooms, intruded on other's conversations, and asked a male resident to assist her in getting undressed. Additionally, she confirmed Resident #4 did not have a BMP. 4. Review of Resident #5's record on 8/23/06 revealed the resident was admitted on 12/29/03 with a diagnosis of dementia. Further review of the resident's record revealed no documented evidence of a BMP. On 8/23/06 at 10:30 a.m., three staff members stated Resident #5 "goes" into Resident #4's room. Additionally, they stated Resident #5 stands in the doorways of the female residents' rooms and, "rubs his penis and attempts to masturbate in front of them." On 8/23/06 at 2:30 p.m., the administrator stated Resident #5's inappropriate behavior had started in May 2006. She stated several female residents had approached her regarding concerns about Resident #5's behavior. She stated that staff have complained to her that during the entire bathing process, Resident #5 has an erection and attempts to touch them. The administrator confirmed she did not have a BMP for Resident #5. The facility failed to develop BMPs for the residents' inappropriate behaviors to help guide staff in the in the intervention for each behavioral symptom. These failures resulted in inadequate care. V. NSA Based on interview and record review it was	R 008	**V. NSA** **1. Corrective actions for specific residents** **A. Resident # 1—NSA developed** **B. Resident # 2—NSA developed** **C. Resident # 3—NSA developed** **D. Resident # 5—NSA developed** **E. Resident # 6—NSA developed** **F. Resident # 7—NSA developed**	

Virginia Wilkerson Administrator 9/19/06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 11 determined the facility failed to develop NSA's to identify and describe residents needs for 6 of 7 sampled residents (#1, #2, #3, #5, #6, and #7). These failures resulted in inadequate care. The findings include: 1. Review of Resident #1's record on 8/23/06, revealed the resident was admitted on 7/6/04 with diagnoses which included middle cervical spinal laminectomy and hypertension. Further review of the resident's record revealed no documented evidence of a current NSA. 2. Review of Resident #2's record on 8/23/06, revealed the resident was admitted on 6/30/06, with diagnoses which included dementia and arthritis. Further review of the resident's record revealed no documented evidence of a current NSA. 3. Review of Resident #3's record on 8/23/06, revealed the resident was admitted on 10/6/03, with diagnoses which included dementia. Further review of the resident's record revealed no documented evidence of a current NSA. 4. Review of Resident #5's record on 8/23/06, revealed the resident was admitted on 12/29/03, with diagnoses which included dementia, hypertension and congestive heart failure. Further review of the resident's record revealed no documented evidence of a current NSA. 5. Review of Resident #6's record on 8/23/06, revealed the resident was admitted on 6/30/06, with diagnoses which included cardiac	R 008	V. continued 2. Identify other residents that may be affected by: A. Review each resident record for a current up-to-date NSA B. Develop current NSAs as needed 3. Measures of changes to make sure does not recur: A. Care plan review committee review all resident NSAs every two weeks for current information. B. Update as necessary C. Licensed nurse review of all resident NSAs every 90 days and develop, update as necessary D. Licensed nurse review of all new admissions for completed NSA 14 days after admission E. Develop log/calendar to track all resident NSAs with dates and required reviews. 4. How corrective actions will be monitored and how often to prevent reoccurrence A. Administrator review NSA log/ calendar every month for completeness and accuracy B. Update as necessary 5. Date corrective action will be completed: October 8, 2006	

Virginia Williams Administrator 9/09/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R118	A. BUILDING _____ B. WING _____	08/24/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY RESTORIUM	6619 KANISKU STREET BONNERS FERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	Continued From page 12 dysrhythmia, arthritis and depression. Further review of the resident's record revealed no documented evidence of a current NSA. 6. Review of Resident #7's record on 8/23/06, revealed the resident was admitted on 6/30/06, with diagnoses which included hypertension and chronic obstructive pulmonary disease. Further review of the resident's record revealed no documented evidence of a current NSA. On 8/24/06 at 10:00 a.m., the administrator confirmed that she had not developed current NSA's for Residents #1, #2, #3, #5, #6, and #7. The facility did not develop NSA's for Residents #1, #2, #3, #5, #6, and #7 to direct staff in the care of the residents.	R 008		

Virginia Williams Administrator 9/19/06

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

September 8, 2006

FILE COPY

Virginia Wilkinson, Administrator
Community Restorium
6619 Kanisku Street
Bonners Ferry, ID 83805

Dear Ms. Wilkinson:

On August 24, 2006, a complaint investigation survey was conducted at Community Restorium. The survey was conducted by Patrick Hendrickson, R.N. and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00001693

Allegation #1: There is not sufficient staff to provide adequate care and meet the needs of the residents.

Findings: Based on observation, interview, and record review it could not be determined the facility did not have sufficient staff to provide adequate care and meet the needs of the residents.

Review of the facility's as worked schedules on August 23, 2006 for the months of July 2006 and August 2006 revealed there were two caregivers and one bath aide on the morning shifts, two caregivers on the afternoon shifts, and one caregiver on the night shift.

During tour of the facility on August 23, 2006 between 8:30 a.m., and 10:30 a.m., 8 random residents interviewed stated there was a sufficient amount of staff to meet their care needs.

Conclusion: Unsubstantiated. Although the allegation may have occurred, it could not be validated during the complaint investigation conducted on August 24, 2006.

Allegation #2: Personnel are not provided training before giving personal care to residents.

Findings: Based on interview and record review it was determined that personnel were not provided training before giving personal care to residents.

Review of 4 random employee files on August 23, 2006 documented 4 of 4 employees did not have documented orientation, continuing education or specialized training.

On August 23, 2006 at 10:30 a.m. the administrator stated she was unaware that employees did not receive orientation, continuing education or specialized training.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.625.01, 16.03.22.630 and 16.02.22.640 for Not providing employees with orientation, continuing education or specialized training. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility's policies and procedures are not current.

Findings: Based on record review it was determined the facility's policies and procedures were not current to IDAPA 16 Tital 03 chapter 22- Residential Care or Assisted Living Facilities In Idaho, 2006 .

Random review of the facility's polices "i.e." behavior management, medications, delegation and staffing on August 23, 2006 revealed the facility's policies were current to IDAPA 16 Tital 03 Chapter 22- Residential Care Or Assisted Living Facilities In Idaho, 2006 .

Conclusion: Substantiated. The facility's policies and procedures are not up to date. The facility was issued a deficiency at IDAPA 16.03.22.153.07, 16.03.22.157.01 d III, IV, V, 16.03.157.01 g I, IV, 16.03.22.157.02 and 16.03.22.162 for policies and procedures (behavior management, medications, delegation and staffing) not being up to date to IDAPA 16 Tital 03 chapter 22- Residential Care or Assisted Living Facilities In Idaho, 2006. The facility was required to submit evidence of resolution within 30 days.

Allegation #4: Medications are left unattended with residents who are not assessed as being self medicators.

Findings: Based on observation and interview it was determined that medications were left unattended with residents who are not assessed as being self medicators.

On August 24, 2006 between 9:00 a.m. thru 10:00 a.m. a tour of the facility was conducted consisting of 35 resident's rooms and 5 of 35 rooms had unattended medications in them.

Review of the above resident's records on August 23, 2006 documented the 5 residents did not have a nursing assessment to self medicate.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.300.06 for the nurse not conducting an assessment on residents who were self medicating. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: Residents are wandering into other resident rooms, taking personal items and intruding on their privacy.

Findings: Based on interview and record review it was determined residents were wandering into other resident rooms, taking personal items and intruding on their privacy.

Review of an identified resident's record on August 23, 2006 revealed the resident was admitted on June 30, 2006, with a diagnosis of dementia.

On August 23, 2006 at 10:30 a.m., 3 staff members stated the identified resident wanders into other resident rooms and "shops".

Review of second identified resident's record on August 23, 2006 revealed the resident was admitted on December 29, 2003 with a diagnosis of dementia.

On August 23, 2006 at 10:30 a.m., three staff members stated the identified resident wandered into other resident rooms.

Review of third identified resident's record on August 23, 2006 revealed the resident was admitted on 10/13/05 with a diagnosis of dementia.

On August 23, 2006 at 10:30 a.m., three staff members stated the identified resident frequently wandered into other resident rooms.

Review of the "Resident Concerns/Issues Report" on August 23, 2006 revealed the following complaints:

On August 4, 2006 (un-timed), "Intrusion of privacy, party frequently comes into my room without knocking... listens to conversations when I have guests and sometimes enters and starts joining in. But today she came into the

bath and started talking to the bath aide while I was in the tub... Somehow there must be some way to stop her, I like my privacy".

On August 11, 2006 at 7:10 a.m., the identified resident had a "loss of temper, upset all the time, confused, entering rooms without permission, wanting help getting undressed."

On August 23, 2006 at 2:30 p.m., the administrator confirmed the three identified residents wandered into other resident rooms and intruded on other's conversations and privacy.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22. 550 for failure to protect the residents' right to a safe living environment and privacy. The facility was required to submit a plan of correction.

Allegation #6: Staff are assisting with medications without being certified to assist with medications.

Findings: Based on interview and record review it was determined staff were assisting with medications without being certified.

Review of personnel records on August 23, 2006 revealed no evidence the staff person who worked the night shift was certified to assist residents with medications.

On August 23, 2006 at 2:30 p.m., the administrator confirmed the staff person who worked the night shift was not certified to assist with medications. Additionally, she stated there were residents who required assistance with medications during the night shift hours.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.645 for failure to assure staff who assisted with medications were certified to do so. The facility was required to submit evidence of resolution within 30 days.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. AND/OR Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Patrick Hendrickson RN

PATRICK HENDRICKSON, R.N.
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A. BUILDING _____ B. WING _____	8/24/06

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Restorium	6619 Kaniksu St. Bonners Ferry, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
160322.1520 Cont.	Or admitted residents IN which the facility could not provide Needed services for residents identified as cosnitivley impaired. These failures placed the residents ~~in harm~~ at risk for harm and caused an immediate danger.		resident as appropriate, a comprehensive Policy statement including specific Guidelines, a behavioral tracking worksheet will be developed by August 29th, 2006. The resulting documents will become part of the PSA and a documented training session in all these matters for all PSA staff will be developed and Copied to H+W by September 6, 2006 Resident Rights: Providing a safe and secure environment for residents requiring assistance with orientation and judgment with our facility will require the design and implementation of an exterior door locking system tied to our emergency response and alarm panel as per fire code. Contractors will be contacted during the week of 8/28 and an expedited	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Virginia Wilkerson	Administrator	8/24/06

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED
8/24/06

NAME OF FACILITY
Community Restorium

STREET ADDRESS, CITY, STATE, ZIP CODE
6619 KANIKSU St BONNERSFERRY, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
16.03.22.520	Inadequate Care - Based on Interview and Record Review it was determined the facility failed to obtain Emergency Services, failed to develop Behavior management plans to ensure residents safety.		Inadequate Care: Regarding the failured to obtain emergency services as per Page 16 of our current Admission Policy procedures were not followed by staff when the incident occured with Mr. Carpenter as cited in the deficiency. The policy statement will be amanded to per current best practices and instructions to sign, reading and understanding this statement will be inserted in the staff communication log by 7pm the date. Once initialed as read and understood, copies of these documents will be provided. Further, the policy will be reviewed with the entire staff during the mandatory staff meeting scheduled for August 31st. A roster of attendees will be constructed and copied as evidence of communicating the procedure to the current staff in regards to the Behavior Management Plans and their implementation for	
16.03.22.550	- Resident Rights - Based on Observation, Interview and record review it was determined the facility failed to provide a safe and secure environment for residents			
16.03.22.152.05	- NON acceptable admissions Based on interview and record review, and observation it was determined the facility retained			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Virginia Wilkerson	Administrator	8/24/06

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	8/24/06

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Restorium	6619 Kanifsu St Bonners Ferry, ID 83805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
160322.1520S CONT.	Or admitted residents IN which the facility could not provide Needed services for residents identified as cognitively impaired. These failures placed the residents ~~no harm~~ at risk for harm and caused an immediate danger.		resident as appropriate, a comprehensive policy statement including education guidelines, a behavioral tracking worksheet will be developed by August 29th 2006. The resulting documents will become part of the PSA and a documented training session in all these matters for all PSA staff will be developed and copied to H+W by September 6, 2006 Resident Rights: Providing a safe and secure environment for resident requiring assistance with orientation and judgment with our facility will require the design and implementation of an exterior door locking system tied to our emergency response and alarm panel as per fire code. Contractors will be contacted during the week of 8/28 and an expedited	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. *(See reverse for further instructions.)* Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
X Vivian Wilkinson	Administrator	8/24/06

Addendum to Bleary Correction - Community Restoration -

installation including a coded key pad at the main entry will be completed by October 15th.

In the interim, beginning immediately, the exit door alarm system will be activated 24-7 and staffing duties will be adjusted to reflect in that of the sitting shift personnel scheduled for 3-11, one person will respond to all door alarms and visually determine the source, and in addition, make a pass through the entire facility to ensure that residents are safely contained. The subsequent graveyard and day shifts will be similarly staffed with identical duties until such time as the ultimate door locking system is installed and functional.

Non Acceptable Admissions

In reference to the two residents identified as out of compliance with our admissions policy, as per 19, "Conditions of Termination" within the policy, families will be contacted and the matter explained to them so they may search out and determine alternate arrangements for these residents. Such arrangements must be executed no later than 7 days from today's date.

In the interim and until such time as the residents are relocated, a behavior modification plan will be developed by the Administrator by noon on Friday August 25th. This plan will be FAXED to Heath and Wellness no later than the specified time and date, and the staff will be instructed in the implementation strategies and documentation required.

X Virginia Wilkins Administrator 8/24/06

3/3.

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Community Restorium	6619 Kaniksu St	208 267-2453
Administrator	**City**	**ZIP Code**
Virginia Wilkerson	Bonners Ferry	83805
Survey Team Leader	**Survey Type**	**Survey Date**
Patrick Hendrickson	Standard + Complaint investigation	8/23/06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	16.0322.215.09	The administrator did not notify the licensing agency of reportable incidents.	10-19-06
2	16.03.22.220	2 of 7 residents' #3,6" did not have a admission agreement	
3	16.03.22.250.14	The facility retained/admitted residents who have a sensitive impairment and did not provide an interior environment which is secure and safe.	
4	16.03.22.260.04	A. Toxic chemicals were not stored at all times under lock and key.	
5	16.03.22.260.04	B no toxic chemicals will be stored in residents ROOMS.	
6.	16.03.22.300.01	The licensed ~~nurse~~ Professional nurse did not visit residents where there was a change in condition.	
7	16.03.22.300.02	The licensee nurse did not review and implement new orders Prescribed by the residents Healthcare Provider.	
8	16.03.22.300.03	The nurse did not contact a nursing supervisor on residents changes in mental or physical Health.	
9.	16.03.22.300.04	The nurse did not make recommendations to the administrator regarding any medical needs or changes to the negotiated service agreement	

Response Required Date	Signature of Facility Representative
9/23/06	Virginia Wilkerson

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Community Restorium	16619 Kaniksu St	208-267-2453
Administrator	**City**	**ZIP Code**
Virginia Wilkerson	Bonners Ferry	83805
Survey Team Leader	**Survey Type**	**Survey Date**
Cedrick Hendrickson	Standard + Complaint Invest.	8/23/06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
~~15~~	~~16.03.22.300.05~~	~~Not all Previous recommendations~~ #1	10-19-06 #4
10	16.03.22.300.06	The nurse did not conduct an initial Nursing assessment on residents	
		that had medications in their rooms Rms, 33, 34, 13, 16, 2.	
11.	16.03.22.310.01	The facility used multi-dose medication distribution systems (i.e. bubble packs) that were not filled	
12.	16.03.22.310.01A	Not All Medications were kept in a locked area. Rms, 2, 16, 13, 33, 34 and in the	
~~13.~~	~~16.03.22.310.01C~~	~~The facility did not ensure that residents have a temperature log.~~ #1	
14.	16.03.22.310.03	The facility did not train medication assistants in accordance with title 37, chapter 27	
		Idaho Code and IDAPA 27.01.01 Rules of the Idaho board of pharmacy. Section 495	
		and Idaho 33. 01.01 Rules of the Idaho Board of Nursing. Section 490.	
15	16.03.22.310.04A	Psychotropic or behavior modifying medication intervention must not be the first	
		line to address behaviors. Resident #4	
16	16.03.22.320	Residents #2 and #6 did not have a written interim Plan	
17.	16.03.22.320.02A	Residents #2, 5 and 6 did not have a current UAE.	
18.	16.03.22.320.08	7 of 7 residents NSA's were not reviewed and updated at least	
		quarterly and at least every 12 months.	

Response Required Date	Signature of Facility Representative
9/23/06	Virginia Wilkerson

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Community Restorium	6619 Koniksu St	208-267-2453
Administrator	**City**	**ZIP Code**
Virginia Wilkerson	Bonners Ferry	83805
Survey Team Leader	**Survey Type**	**Survey Date**
Patrick Hendrickson	Standard + Complaint Invest	8/23/06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
19	16.03.22.350.02	not all Incidents or accidents or complaints had a written report of findings.	10/9-06 AH
20	16.03.22.350.04	Written responses of complaints were not provided to the person making the complaint	
~~21~~	~~16.03.22.350.07~~	~~When a reportable incident occured the~~ AH	
21	16.03.22.405.01.B.	Rooms 2, 12, 13 and 10, 11 had extension cords and/or multiple electrical adapters without built in breakers.	
22	16.03.22.405.03	Room 1 had unrestrained medical gasses.	
23	16.03.22.600.06.b	3 employees served meals who did not have current CPR or first aid.	
24	16.02.22.625.01	4 of 4 Employees did not have a minimum of 16 hours Job related orientation training.	
25	16.02.22.630	4 of 4 Employees did not have specialized training.	
25	16.02.22.640	4 of 4 Employees did not receive Job related continuing training.	
26	16.02.22.645	1 Employee passed medications without proof of medication certification.	
27	16.02.22.650.02	4 of 4 Private Pay residents "2, 4, 5 and 6" did not contain all necessary components in the NSA/IHP	

Response Required Date	Signature of Facility Representative
9/23/06	Virginia Wilkerson

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Community Restorium	60049 Kaniksu St	208-267-2453
Administrator	**City**	**ZIP Code**
Virginia Wilkerson	Bonners Ferry	83805
Survey Team Leader	**Survey Type**	**Survey Date**
Patrick Hendrickson	Standard + Complaint Invest	8/23/06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
28.	16.03.22.710.04	3 of 7 residents records did not have a Prior History and Physical #2, 5 and 6.	10-19-06
29.	16.03.22.711.01 A, B, C	Residents #3, 4 5 did not contain behavior management.	
30.	16.03.22.711.04	Resident's records did not contain potential care consequences.	
31.	16.03.22.711.08	A – F Residents records did not contain all care notes as described in Rule 6. Ø Mars and all others.	
32	16.03.22.730.01	F. 3 of 4 employee records did not contain first aid and/or CPR and/or medication certification.	
33	16.03.22.730.04	F 4 of 4 Employees did not have documentation of delegation.	
34.	16.03.22.153.07	The facility did not have a Policies for behavior management.	
35.	16.03.22.157.01	(i, iii, iv, v)(6, i, iv) The facility's policies did not address total's for review.	
36.	16.03.22.157.02	The facilities policies did not articulate the process the nurse will use to delegate assistance with medications.	
37.	16.03.22.162	The facility did not have a policy for staffing.	
38.	16.03.22.350.05	The facility did not notify A.P. in accordance with Section 39-5303	

Response Required Date
9/23/06

Signature of Facility Representative
Virginia Wilkerson

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name	Physical Address	Phone Number
Community Restorium	669 Kaniksu St	267-2453
Administrator	**City**	**ZIP Code**
Virginia Wilkerson.	Bonners Ferry	83805
Survey Team Leader	**Survey Type**	**Survey Date**
P. Hendrickson	S/S	8-23-06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
#39	16.03.22.300.02	The facility did not have a licensed available to address change in the resident's Health status.	10-19-06 dl

Response Required Date	Signature of Facility Representative
9-23-06.	Virginia Wilkerson